FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

X Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

X Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

X Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

X Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **North Carolina**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Paul R. Perruzzi

(Signature of Agency Head)

SCHIP Program Name **North Carolina Health Choice for Children**

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
X____ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date January 4,2001

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter >NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility --**Through plan amendment IV, the two month period of uninsurance has been eliminated for children with special needs**

2. Enrollment process – **Children with special needs only must present a signed doctor's statement or insurance statement to waive the two-month eligibility period**

3. Presumptive eligibility--**NC**

4. Continuous eligibility--**NC**

5. Outreach/marketing campaigns—**NC**

6. Eligibility determination process--**NC**

7. Eligibility redetermination process--**NC**

8. Benefit structure – **Annual pap exams are now part of the basic services; mental health preventive health benefit inaugurated in which the first 6 mental health visits are uncoded and unmanaged.**

9. Cost-sharing policies—**Through Plan Amendment IV members of federally recognized Native American Tribes who present tribal identification card do not have any out of pocket costs for the program.**

10. Crowd-out policies--**NC**

11. Delivery system -- **NC**

12. Coordination with other programs (especially private insurance and Medicaid) --**NC**

13. Screen and enroll process --**NC**

14. Application --**NC**

15. Other --**NC**

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

The total number of uninsured low-income children in North Carolina has decreased in the last year. For children under 200% of the federal poverty level, there were 119,081 uninsured children in FY 1999 (14.5%) and 108,849 uninsured in FY 2000 (13.3%). The overall 1.2 percentage point decrease results from a number of changes: the percent of low-income children covered by NCHC coverage increased by 2.1 percentage points, Medicaid increased by 1.1 percentage points, and coverage by other forms of insurance decreased by 2 percentage points.

For children 201-300% of the federal poverty level, there were 63,763 uninsured children in FY 1999 (17.2%) and 53,583 uninsured in FY 2000 (14.5%). For these children, the decrease in the number and rate of uninsured was due to an increase in private insurance coverage.

Methodology (as reported in the March 2000 Evaluation): The number of uninsured children was estimated in 6 age/income cells—age was divided into tow categories (less than 6 and 6-18 years old), and income was divided into three categories (less than or equal to 200% FPL, 201-300% FPL, and greater than 300% FPL). In each age category, the total number of children was based on 2000 data from the Office of State Planning. These totals were distributed across the income cells within each age category based on the income distribution found in the combined 1998, 1999, and 2000 CPS. Subtracted from the total number of children in each age/income cell was the actual number of Medicaid and NC Health Choice eligibles in the month of September 2000 (pulled from the DRIVE query in December 2000), and the estimated number of children covered by other, non-Medicaid non-NCHC sources of insurance. The remainder is our estimate of the number of uninsured children. To estimate the number of children that were covered by non-Medicaid non-NCHC insurance, we took the percentage of non-Medicaid non-NCHC children in that age/income cell in the combined 1998, 1999, and 2000 CPS who were covered by other forms of insurance, and applied that percentage to the total number of non-Medicaid non-NCHC children (based on actual Medicaid eligibles and OSP population numbers) in the cell.

Note: We encountered a problem in the analysis of the Current Population Survey. Although in the survey itself there is now a question about coverage under S-CHIP programs, in the 2000 CPS we could not find a variable quantifying these responses. Although we made every effort to contact individuals in Washington to find out where the S-CHIP children were classified, we did not receive an answer before the numbers had to be calculated in order to meet HCFA reporting deadlines. We have made the assumption that the S-CHIP children have been aggregated in with the Medicaid children. If we should find out later that this is not true, it is possible that our calculations will change slightly.

FFY 1999

	LE 200%	%	201-300%	%	GT 300%		Total	
<6 Medicaid	224,579	85.0%	203	0.2%	563	0.2%	225,345	36.4%
Health Choice	12,502	4.7%	3	0.0%	0	0.0%	12,505	2.0%
Other insurance	16,014	6.1%	98,599	82.7%	221,854	94.3%	336,468	54.4%
Uninsured	11,000	4.2%	20,424	17.1%	12,862	5.5%	44,287	7.2%
Total children	264,096	100.0%	119,230	100.0%	235,280	100.0%	618,605	100.0%
6-18 Medicaid	272,660	49.0%	82	0.0%	136	0.0%	272,878	20.4%
Health Choice	44,338	8.0%	7	0.0%	0	0.0%	44,345	3.3%
Other insurance	131,354	23.6%	207,609	82.7%	501,585	94.3%	840,548	62.8%
Uninsured	108,081	19.4%	43,339	17.3%	30,262	5.7%	181,681	13.6%
Total children	556,432	100.0%	251,037	100.0%	531,983	100.0%	1,339,452	100.0%
Total Medicaid	497,239	60.6%	285	0.1%	699	0.1%	**498,223**	**25.4%**
Total Health Choice	56,840	6.9%	10	0.0%	0	0.0%	**56,850**	**2.9%**
Total other insurance	147,368	18.0%	306,208	82.7%	723,439	94.3%	**1,177,015**	**60.1%**
Total Uninsured	119,081	14.5%	63,763	17.2%	43,125	5.6%	**225,969**	**11.5%**
Total Children	820,528	100.0%	370,266	100.0%	767,263	100.0%	**1,958,057**	**100.0%**

FFY 2000

	LE 200%	%	201-300%	%	GT 300%	%	Total	
<6 Medicaid	223,240	87.3%	27	0.0%	5	0.0%	223,272	36.0%
Health Choice	15,916	6.2%	0	0.0%	0	0.0%	15,916	2.6%
Other insurance	9,975	3.9%	101,347	85.5%	232,579	94.4%	343,901	55.4%
Uninsured	6,614	2.6%	17,187	14.5%	13,849	5.6%	37,651	6.1%
Total children	255,745	100.0%	118,561	100.0%	246,434	100.0%	620,740	100.0%
6-18 Medicaid	283,397	50.1%	40	0.0%	7	0.0%	283,444	20.9%
Health Choice	58,229	10.3%	0	0.0%	0	0.0%	58,229	4.3%
Other insurance	121,621	21.5%	214,091	85.5%	511,754	94.6%	847,466	62.5%
Uninsured	102,235	18.1%	36,396	14.5%	29,212	5.4%	167,843	12.4%

Total children	565,482	100.0%	250,526	100.0%	540,973	100.0%	1,356,983	100.0%
Total Medicaid	506,637	61.7%	67	0.0%	12	0.0%	**506,716**	**25.6%**
Total Health Choice	74,145	9.0%	0	0.0%	0	0.0%	**74,145**	**3.7%**
Total other insurance	131,596	16.0%	315,437	85.5%	744,334	94.5%	**1,191,367**	**60.2%**
Total Uninsured	108,849	13.3%	53,583	14.5%	43,061	5.5%	**205,494**	**10.4%**
Total Children	821,227	100.0%	369,088	100.0%	787,407	100.0%	**1,977,723**	**100.0%**

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

See above

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

See above

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the number of uninsured children under 200% of the federal poverty level	**Reduce the number of children by 35,000**	Data Sources: NC Health Choice enrollment data Methodology: Actual NC Health Choice enrollment numbers, supported by information about crowd-out learned from Sheps Center Study (see question 2.3.3) Progress Summary: This objective was met in the first year of the program. The number of uninsured children continues to be reduced, as there are 17,295 more children enrolled in NC Health Choice than there were a year ago. Analysis of the Sheps Center Survey data suggests that most of these children would be uninsured, but for the creation of the NC Health Choice program. In addition, as reported in 1.2.1, the reduction of the number of uninsured appears to be due to a combination of increased enrollment in NC Health Choice and increased enrollment in Medicaid (which may be due to outreach efforts associated with the implementation of NC Health Choice.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
To simplify the intake process of both Title XXI and Title XIX eligibles	**50% of our applications will come through the mail**	Data Sources: Computerized files kept on location of application filed Methodology: comparison of applications filed at county social services, county public health and through the mail Progress Summary: The data shows that 87% of the applications are made at the county departments of social services offices while only 12% come in through the mail. The other one percent are made at the county public health offices.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
To simplify the intake process of both Title XXI and Title XIX eligibles	**50% of our applications will come through the mail**	Data Sources: Computerized files kept on location of application filed Methodology: comparison of applications filed at county social services, county public health and through the mail Progress Summary: The data shows that 87% of the applications are made at county departments of social services offices, 12% through the mail and the remaining one percent at county health departments.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
To increase awareness of health care coverage options through an outreach campaign.	**Fully implement outreach plan**	Data Sources: Outreach activities reported in each of the state's 100 counties. Methodology: Assessments of numbers of children enrolled in each county compared to original targeted number Progress Summary: Enrollments have far surpassed targets. A total of 72 counties had 85% or better of their original targets, with 51 counties having enrolled 100% or higher. No county had enrolled below 50% of their original target goal. The counties with the lowest percentage enrollments of NC Health Choice Children have the lowest incomes and higher rates of Medicaid enrollments.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
To encourage utilization of preventive health care services	The average number of visits per enrolled child will equal or exceed the Title	Data Sources: HEDIS 2000 specifications were used to determine the rates for Health Choice Recipients

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
To increase child health screenings among enrolled children	XIX rates At least 50% of enrolled Title XXI children will be screened in the first year with 80 percent of enrollees screened within five years	Methodology: A primary care provider was defined as the following provider types: General Practice, Internal Medicine, Pediatrics, Family Practice, and Family Nurse Practitioner. These provider types match the definition of primary care provider that was used in determining the NC Medicaid HEDIS rates. In addition, obstetrics/gynecology was added as a primary care provider for adolescent and well child visits. Progress Summary: Well child visits in the third, fourth, fifth and sixth year of life Numerator: 1275 Denominator: 2803 Rate 45.5% National Medicaid Benchmark 51% Adolescent Well Care Visits (The age range was modified to Age 12-18 since the CHIP program discontinues enrollment at the 19th birthday) Numerator: 1357, Denominator 6837, Rate 19.8%, National Medicaid Benchmark 27%

OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1. Regarding North Carolina's performance goal of having 50% of all applications arrive through the mail. The state feels that this is not an adequate measure of the ease of application, but rather a misguided judgement call on the state's part as to preference of method of application. Surveys indicate that applicants love the two page application form and consider applying for the program to be very easy, yet they tend to bring the application into an office rather than mail it. Informal conversations indicate that the reason may be a concern that the applicant cannot count on the mail to get the application to the social services office in a timely manner. A one-county survey by the Robert Wood Johnson Covering Kids campaign indicates that North Carolina Medicaid does not suffer from the stigma problem that other states' programs reports. This lack of "stigma" may also encourage families to simply take their applications to the local social services offices rather than relying on the mail to deliver them. That 80% of the NC Health Choice members are Medicaid graduates may also ease any potential concerns families may have had regarding taking their application to a county office. The state may need to file a plan amendment to change the measure of easing the application process to that of how many children enroll or reenroll each month. During the last quarter of the 2000 fiscal year, an average of 1,000 new children a week were enrolling in NC Health Choice.

2. Regarding rates of well-child screenings. North Carolina's program is offered as an any willing provider, fee for service program. Efforts to design methods to encourage well-child visits are underway. It is likely that the measure that the performance goal defines an ideal rather than a realistic and achievable goal. The state may need to file a plan amendment to change the measure of improving standards for well child visits.

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

As discussed in our report submitted to HCFA in March, 2000, staff at the Cecil G. Sheps Center for Health Statistics Research at the University of North Carolina at Chapel Hill are conducting a study about perceived access to care for NC Health Choice enrollees. Partial results from the Sheps Center student are discussed in a number of questions I this report. The final report from this study will be available in Spring, 2001.

The CAPHS survey is due during the month of January, 2001 and will be filed as a late addendum to this report.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

Two memos from Cecil G. Sheps Center: likes and dislikes; provider willingness to accept NCHC

The Blue Cross Blue Shield Utilization Report

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: Not applicable

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults_____
   Number of children_____

3. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: Not applicable

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program? **Those who drop health insurance in order to meet the eligibility standards for the S-CHIP program**

2. How do you monitor and measure whether crowd-out is occurring? **Through a survey (see below)**

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

The study of NC Health Choice that is being conducted by staff of the Cecil G. Sheps Center

for Health Services Research surveyed the parents of newly enrolled children in the summer of 1999 (time 1). Respondents were then sent a follow-up, time 2 survey in the summer of 2000. We also surveyed a group of new enrollees I the summer of 2000 using the time 1 survey to examine 1) if new enrollees were appreciably different from those who enrolled one year earlier and 2) if their pre-NCHC access to care was also different. Out of 500 new enrollees surveyed, 371 parents responded, for a 71.3% response rate.

Among the respondents in the new group of NC Health Choice enrollees, there were a very small number among whom crowd out could even be considered. Over 63% reported that their child's last form of insurance had been Medicaid, and 10% reported that their child had never had health insurance. For children whose most recent insurance was a private policy, the majority (22.6% of all respondents, 84 children) had insurance through their parent's employer. Very few (1.6% of all respondents, 6 children) had previous insurance that their parent bought personally. Among these 90 children with private coverage, over half (58) lost that coverage because their parent changed or lost their job. Only two individuals (less than ½% of respondents) reported that they dropped their child's previous coverage in order to qualify for NC Health Choice.

As discussed in our March 1999 report to HCFA, we recognize that parents may underreport intentional dropping of previous coverage. Another possible measure of crowd-out is the percent of people who had private insurance but reported dropping it for other reasons. For those who reported the date their child's last insurance coverage ended, i.e. "uninsurance" in order to qualify for NC Health Choice, only 13 parents (3.5% of respondents) who dropped insurance because it was too expensive did so in the months leading up to NC Health Choice coverage. Just as many 11 had dropped coverage in a prior year, so long ago as to not be likely to have been attempting to become uninsured in order to qualify. These estimates of crowd-out (<1-3.5%) are consistent with the range reported last year.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information. **Crowd-out does not appear to be enough of an issue to justify in-depth analysis of this problem. The program is advertised as a program for uninsured children. Having insurance is a reason for denial of approximately 19% of those who apply for the program and are denied. This is the third leading reason for denial with 30 percent being denied for failure to pay the enrollment fee and 26 percent being denied because their income was too high.**

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The time 1 survey sent to a second group of new enrollees described in question 2.3.3 asks

respondents how they heard about NC Health Choice. The most common response was Department of Social Services (62%). In addition, 25% of respondent learned about the program from the health department, 9% heard about it from another health care provider, 9% from their child's school or daycare. 9% from the media, 9% from posters or billboards, and 7% from friends or coworkers. (Respondents could mention more than one source of information, so percents add to more than 100.)

North Carolina has done well with SCHIP outreach because the major thrust was a local grassroots outreach coalition strategy. Beyond the local approach, the most effective activities in reaching the low income, uninsured population have been outreach through schools, child care providers and public agencies (local departments of social services and health).

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Hispanic children were much more likely to be reached through the public health department compared to other children (58% compared to 24% of whites and 21% of blacks). They were also much less likely to hear about NC Health Choice from the Department of Social Services (38% of Hispanics, compared to 62% of whites and 68% of blacks).

Rural residents were more likely than urban residents to report hearing about the program from another health care provider (13% versus 6%) and from billboards (12% versus 6%).

Through our Duke Endowment Health Choice Minority Outreach Grant, we are targeting outreach to African American, Latino and American Indian communities. What we have learned from those projects is that outreach is most successfully accomplished when the message is delivered personally from someone they trust. Different projects have used door to door canvassing, home visiting, and outreach to community agencies, organizations, health care providers, businesses, media and churches that specifically serve the population being targeted. The Covering Kids Projects have also identified the same factors from targeting minority and immigrant populations in their counties. Outreach and enrollment materials are translated into the Spanish and interpreter services are available at many sites where enrollment occurs and where health car services are provided.

3. Which methods best reached which populations? How have you measured effectiveness?

See above

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

- State is doing re-enrollments by mail so families do not have to lose time at work

- State mails post card reminder
- Families that do not return the mail-in reenrollment form are reminded by the local agencies that they risk losing benefits unless the form is returned
- State has a "grace period" for accepting late re-enrollments which is the first 10 calendar days of the month following the end of the enrollment period
- Some counties are deputizing volunteers and/or other community agency staff to do personal follow-up with families do to re-enroll (after signing a "confidential information agreement."
- Other counties are trying a variety of other strategies: for example, Spanish notices, autodialers, media coverage regarding re-enrollment, community service providers and health care providers reminding families to re-enroll, DSS outstationed workers take re-enrollment application forms, employers assist with re-enrollment effort and provide documentation of income, Health Check coordinator helps with re-enrollment outreach, marketing re-enrollment from the time families initially enroll, hire part-time person to assist with reenrollment

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

- Follow-up by caseworkers/outreach workers
- Renewal reminder notices to all families

____ Targeted mailing to selected populations, specify population _____

- Information campaigns

____ Simplification of re-enrollment process, please describe _____

____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____

- Other, please explain 100 counties were surveyed, 81 responded. Regarding reenrollment: 22% sent additional letters, postcards and/or reenrollment application forms to remind families to re-enroll, 11.5% deputized volunteers and/or other agency staff to do personal follow-up with families due to re-enroll (after signing a "Confidential Information Agreement."; 44% used DSS staff to do personal follow-up with families due to reenroll, 22% used other reenrollment strategies.

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, the same measures are being used in Medicaid. There is a joint outreach effort.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

North Carolina does not have evaluation data to indicate which strategies encouraging reenrollment have been the most effective. Our belief is that active personal outreach rather than a passive process should yield better results, but this is unproven.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Among the 987 respondents to a survey of parents of NC Health Choice enrollees conducted approximately one year after their child's initial enrollment by staff from the Cecil G. Sheps

Center for Health Services Research, 189 children (19%) reported that they had other insurance. Among the 189, about half (96) reported that they had other insurance. Almost 44% of the 96 children who left NC Health Choice because of other insurance reported being back on Medicaid. Parents of 13% (12 children) reported having private insurance, and for the remaining 44%, the type of insurance is unknown.

The 81% of respondents whose children were still enrolled in NC Health Choice included some children who had already reenrolled for a second year but mostly those who have not yet reapplied. Those still enrolled (both those who had already reapplied and those who had not) were asked whether they intended to reenroll their children. Only 28 parents (3.5% of those whose children were still enrolled) responded that they did not intend to reapply for the program. Of these, 14 percent said that they could get other insurance, including 3 who were going back to Medicaid.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes. We use one application form for both SCHIP and Medicaid. The same caseworker makes the determination Income verification at application must be verified. At reenrolllment requirements for verifying income are the same. Both require income to be verified.

2. Explain how children are transferred between Medicaid and SCHIP when a child=s eligibility status changes.

A child's eligibility is determined once every 12 months unless the parent applies for a cash payment program (TANF, SSI). If the parent applies and is approved for a cash payment program, the child's eligibility in NC Health Choice is terminated and the child receives a Medicaid eligibility card. Upon reenrollment, if a child is determined eligible for Medicaid, he or she is issued a Medicaid eligibility card and is denied for NC Health Choice. If at redetermination a Medicaid recipient is found to be NC Health Choice eligible, the child will be disenrolled from Medicaid and enrolled in NC Health Choice, provided with an NC Health Choice card, etc.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

No, Medicaid in North Carolina is predominately a PCCM system, while NC Health Choice is an any-willing provider fee for service system. There is a lot of overlap in the two systems because a large percentage of the primary care physicians and pediatricians in the state do participate in Medicaid.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

The state has only looked at the reasons for denial and found that the enrollment fee has consistently been the leading reason for denial in the program.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

The state has attempted no assessment of the effects of cost-sharing on utilization of health services under SCHIP.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results. **We have conducted a CAHPS survey to determine family satisfaction with care. Those results should be ready in January, 2001. I will forward them when I get them.**

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care? BCBS Utilization (attached.)

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available? **Currently the NC Teachers and State Employees Comprehensive Major Medical Plan is in the process of establishing a disease management component targeted to several major illness categories –asthma, diabetes, heart disease. NC Health Choice children will be a part of this disease management component. It is expected to be up and running with data to report within the year.**

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter >NA= for not applicable.

1. Eligibility – The floods which incapacitated one-third of the state beginning in the fall of 1999 presented a particular challenge to counties and state officials in regard to NC Health Choice. It was the beginning of our re-enrollment period, therefore a special provision was added for the families in those counties. Families due for-reenrollment, who had not reenrolled by September 27th were authorized for continued coverage through October 31st and were mailed a letter as proof of coverage. For a few of the very hardest hit counties, this coverage was extended through December, 1999. The extra effort this entailed, along with the brochures for NC Health Choice and Health Check that went out on the rescue boats assured that families had the health care coverage they needed.

2. Outreach—North Carolina's outreach effort has been so successful that we have reached capacity. Here are some of the hallmarks of outreach for the 1999-2000 ffy.

- School flyers were sent home with all children statewide once; local coalitions did additional distribution of materials through schools.
- In October 1999 the Governor headed up the one-year anniversary celebration of the program.
- Outreach targeted to families terminated from Work First and families identified through a match with Food Stamps, Day Care and the Low Income Energy Assistance Programs
- Hispanic/Latino Outreach Campaign called the Ana Maria Campaign, developed with the assistance of the Latino Work Group. New, more culturally sensitive materials developed.
- TV and radio ads discussing enrollment and re-enrollment were placed strategically throughout the state where enrollment numbers were below average
- Began work on a business outreach initiative

Latino Work Group

A Latino work Group convened as a subcommittee of the State Health Check/NC Health Choice Outreach Coalition. They advocate for the needs of the Latino population and work to remove barriers. Recent efforts have included

1. Recommended revisions to the state application as well as translations of other forms/letters used by state and county agency
2. Identification of Spanish speaking contacts at county level to whom families may be referred from our bilingual NC Family Health Resources Line
3. Developed a directory of clinics who are able to serve uninsured populations (eg. Latino families

who may not qualify for Medicaid or NC Health Choice due to five-year waiting periods or other barriers.)

4. Developed a network of individuals within the Latino communities across the state who can share programmatic information and updates

Grant funded projects:

RWJ Covering Kids Project

In North Carolina, the Covering Kids Initiative has five county-based projects in Buncombe, Cabarrus, Edgecome, Forsyth and Guilford Counties. These projects targeted outreach at specific segments (business, provider and faith community outreach) and special populations (Latino community and African American adolescents). Products have included Business, Provider and Latino Outreach Kits, a revised family friendly application form, strategies for re-enrollment and development of a videotape for use in waiting rooms.

Duke Endowment Projects:

The Duke endowment has provided funding to seven multi-county projects with the objective of enrolling minority children in Health Check/NC Health Choice and increasing their utilization of preventive care. In order to do this these projects provide focused outreach in particular geographic areas to learn the best ways to enroll American Indian, African American and Hispanic/Latino children.

Children With Special Health Care Needs:

- A Health Choice program benefits handbook entitled "Information for Children wth Special Needs and their Parents was developed specifically for families of children with Special Needs and their families
- Another booklet was developed specifically to explain the Emergency Respite Care benefit
- The Commission on Children with Special Health Care Needs was instrumental in the passage of legislation to assure the exemption of children with special needs from the two-month period of uninsurance.

3. Enrollment -- Enrollment in the NC Health Choice Program reached 67,231 by the end of the fiscal year.

4. Retention/disenrollment – Efforts continue to improve retention in the program

5. Benefit structure – Two benefits were added to the base plan. (1) Annual Pap Smears are now provided as a preventive health benefit for females in the program (2) A preventive mental health benefit was created allowing for 6 uncoded, unmanaged visits to a mental health or substance abuse provider. The concept behind this benefit is that often school counselors, principals, parents and others may be reluctant to refer a child for a mental health visit if such a visit would unnecessarily stigmatize the child. This allows for a diagnostic referral without a presumed diagnosis.

6. Cost-sharing - NC

7. Delivery systems - NC

8. Coordination with other programs- NC

9. Crowd-out- NC

10. Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments	$81,850,663.40	$101,552,101.98	$120,673,228.87
Managed care			
per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs			
Personnel	$155,471.75	$203.723.75	$201,973.85
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs	$300,000.00	$350,000.00	$175,000.00
Other/eligibility determination	$6,608,349.00	$6,776.300.00	$6,414,200.00
Total Administration Costs	$7,063,820.75	$7,330,023.75	$6,791,173.85
10% Administrative Cost Ceiling	$8,185,066.34	$10,155,210.20	$12,067,322.89
Federal Share (multiplied by enhanced FMAP rate)	$65,663,346.54	$80,278,791.30	$93,711,828.88
State Share	$23,251,137.61	$28,602,224.43	$33,752,573.84
TOTAL PROGRAM COSTS	**$88,914,484.15**	**$108,882,125.73**	**$127,464,402.72**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__x__ State appropriations
_____ County/local funds
_____ Employer contributions
__x__ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		NC Health Choice for Children
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff __X__Other *(specify)* County Medicaid eligibility staff
Average length of stay on program	Specify months _____	Specify months __7.6__
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	__X__No _____Yes
Can apply for program over internet	_____No _____Yes	_X__No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Requires face-to-face interview during initial application	_____No _____Yes	___X_ No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __X__Yes, specify number of months _2 months_ What exemptions do you provide? Special needs, Medicaid graduates, no-fault loss of insurance
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No __X Yes, specify number of months _12___ Explain circumstances when a child would lose eligibility during the time period *If family makes application for and is granted Medicaid eligibility (SSI, etc.)*
Imposes premiums or enrollment fees	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No x__Yes, how much? __Enrollment fee $50 for one child $100 for two or more children_____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship _x_ Other (specify) _anyone_____ _____
Imposes copayments or coinsurance	_____No _____Yes	_____No _x___Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	___X__ No Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct and income verification ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

Reenrollment form is automatically mailed to client in 10th month of a 12 month enrollment period. It has the casehead's name and address printed on it. The rest of the information must be filled out and one-month of paystubs provided to verify income.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	___185_% of FPL for children under age __1_____ __133__% of FPL for children aged __1-5_____ __100__% of FPL for children aged ___5-21_____
Medicaid SCHIP Expansion	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	_200___% of FPL for children aged __0-1_____ _200__% of FPL for children aged ____1-5___ _200_% of FPL for children aged ___5-19_____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes ___X_ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$ 90 deduction	$	$90 deduction
Self-employment expenses	Operational expenses plus $90 deduction	$	Operational expenses plus $90 deduction
Alimony payments Received	$50 deduction	$	$50 deduction
Alimony payments Paid	Deduct amount paid if court ordered	$	Deduct amount paid if court ordered
Child support payments Received	$50 deduction	$	$50 deduction
Child support payments Paid	Deduct amount if court ordered	$	Deduct amount if court ordered
Child care expenses	up to $200/month each child child under 2 and $175/mo for each child age 2 and over	$	$ up to $200/month each child under 2 and $175/mo for each child 2 and over
Medical care expenses (incapacitated adult care)	Up to $175 a	$	Up to $175 a

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
	month		month
Gifts	excluded	$	excluded
Other types of disregards/deductions (specify) EITC	Total amount	$	Total amount

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups __x__No ____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program __n/a__No ____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program __x__No ____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____ __n/a__No ____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _x__ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

GENERAL: WITH A NEW LEGISLATURE AND NEW GOVERNOR TAKING OFFICE IN JANUARY, 2001THEIR INTENTIONS ARE NOT YET KNOWN. FROM THE AGENCY'S PERSPECTIVE AS OF THE END OF Calendar 2000, THE FOLLOWING IS ACCURATE.

1. Family coverage

2. Employer sponsored insurance buy-in

3. 1115 waiver

4. Eligibility including presumptive and continuous eligibility

5. Outreach

6. Enrollment/redetermination process

7. Contracting

8. Other **Because our federal allocation and the state budget requires that we maintain an average enrollment no greater than 68,970 and the enrollment as of December 1, topped 70,000 we are preparing to freeze new enrollments effective January 1, 2001 pending approval by HCFA of a plan amendment.**